United Response

United Response - 26 Tennyson Road

Inspection report

26 Tennyson Road
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 29 August 2018 and was unannounced.

26 Tennyson Road provides care and support for up to five people with a learning disability. At the time of this inspection there were five people living at the home. The home is a detached residential property located in a suburban area of Bognor Regis. Each person had their own bedroom which was decorated in the way they had chosen. There was a communal lounge and a dining room. Bathroom and toilet facilities were provided on both floors of the home.

At the last inspection of 31 May 2017, we found the provider was in breach of three regulations. The provider had failed to notify us of incidents which they were required to do as set out in regulations. The provider had not taken sufficient action to ensure people were always protected from harm, which had placed people at risk of abuse. We found the provider had not operated a system of adequate monitoring of the quality and safety of the service to ensure people were always protected from harm, which had placed people at risk of abuse. We made a requirement notice regarding this and the provider sent us an action plan of how they would be addressing this. At this inspection improvements had been and all three breaches had been met.

The service did not have a registered manager, but there was a manager who had applied to the Commission to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we identified some of the safety checks regarding risks to people and staff regarding the premises were not properly assessed in line with health and safety guidance. We have made a recommendation about this.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Staff were trained in safeguarding people in their care. Relatives said staff had a good awareness of their responsibilities to protect people.

Risks to people were assessed and care plans included details of action staff needed to take to keep people safe.

Sufficient numbers of staff were employed to meet people's needs and to ensure people had access to community facilities.

Medicines were safely managed.

The home is a converted residential dwelling. People were able to choose the décor for their rooms which were personalised with their own belongings.

People's health and social care needs were comprehensively assessed and arrangements made to monitor and treat health care needs.
Staff had access to a range of training courses including nationally recognised qualifications in care. Staff were also supported with supervision and their performance was monitored by regular appraisals.

People chose the meals they had and people had nutritious meals.
Staff supported people to make their own decisions and to have as much control about their lives as possible. Staff were trained in the Mental Capacity Act 2005 (MCA) and in the Deprivation of Liberty Safeguards (DoLS).

People received care from staff who were caring and compassionate. People were involved in decisions about their care. Relatives described the home as being like a family. People were supported to develop their independence and their privacy was promoted.

People received person centred care which was responsive to their needs. Care plans reflected people's needs and preferences, although the manager acknowledged these needed to be reviewed and updated. People were supported to attend a range of social and recreational and occupational activities. People's communication needs were assessed and staff were skilled when interacting with people. Information was provided to people in a format they could more easily understand.

People and their relatives were able to contribute to decision making in the home. Relatives and staff said the manager was supportive and approachable. Staff said they were supported. The provider promoted an ethos of person centred care where people's rights to care were upheld. There were a number of audits and quality assurance checks regarding the safety and quality of the services.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The premises and equipment were safe and well maintained with the exception of measures to protect people from hot surfaces and systems to assess and combat the risks of Legionnaire's disease.

Staff had a good awareness of safeguarding procedures for people in their care.

Risks to people were assessed and measures put in place so people could undertake daily activities whilst being safely supported.

Sufficient numbers of staff were provided to meet people's needs.

Medicines were safely managed.

The home was found to be clean and hygienic.

Incident and accidents to people were reviewed and appropriate action taken.

Is the service effective?

Good

The service was effective.

Staff had access to guidance and information from the provider and other organisations regarding the care of people.

Staff were well trained and supervised.

People were supported to eat and drink enough. There was a choice of nutritious food.

Health care needs were met and the provider worked with health care services to ensure people got the correct treatment.

The premises were homely and suitable for the people who lived there.

People were fully consulted about their care and the provider followed procedures where people did not have capacity to consent to their care as set out in the MCA.

Is the service caring?

Good

The service was caring.

People received care from staff who were kind and caring.

People were consulted and involved in decisions about their care.

The provider promoted people's privacy and independence.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed. Care plans showed how people were to be supported although we noted some of these needed to be updated; the manager confirmed the care plans were to be reviewed and updated. People were supported to attend a range of social, recreational and occupational activities.

People and their relatives said they were able to raise any concerns which were acted on.

Care plans referred to arrangements for possible end of life care where this was relevant.

Is the service well-led?

Good

The service was well led.

There was a new manager in post who had applied for registration with the Care Quality Commission.

The home had a culture where people and relatives were involved in decisions about the home.

There was a system of audits of the quality and safety of the service which included seeking the views of people, their families and health and social care professionals.

The provider had good links with organisations to ensure people received coordinated care.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 August 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people. Following the inspection, we spoke to two relatives of two people who lived at the home. We spoke with two care staff, the lead senior support worker and the manager. We spent time observing the care and support people received in communal areas of the home. We also spoke to a social worker who monitored a person's care at the home.

We looked at the care plans and associated records for three people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents, records of medicines administered to people and complaints.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of 31 May 2017, we found the provider had not taken appropriate action where there were safeguarding concerns. This included the local authority safeguarding team not being notified of incidents where people were not safe. We made a requirement notice for this. The provider sent us an action plan of how this was to be addressed. At this inspection we found people were safely supported by staff. There were care plans about people's behaviour and how to deal with this, such as identifying when a person's behaviour may change and the action staff should take to keep people safe. There were no incidents where the provider had failed to take appropriate action. People's relatives said safe care was provided and that people were looked after well. A social care professional who monitored a person's placement at the home was satisfied their client was looked after well. For example, the professional said the arrangements for care had been successful in providing a fulfilled lifestyle which had a positive effect on behaviour. There were good systems and processes regarding the safeguarding of people. Notices were displayed in a format which made it easier for people to understand so they could alert staff if they had concerns. Staff were trained in safeguarding and had a good understanding of the principles of protecting people and who to report any concerns to. We judged this requirement was now met.

We identified radiators were not covered and there was no risk assessment regarding the possibility of people being burned by hot surfaces. Following the inspection, the manager confirmed arrangements were made for the radiators to be covered. The provider did not have a system for assessing and managing the risks of legionella as set out in the Health and Safety Executive (HSE) publication Health and Safety in Care Homes. This advises an assessment by a competent person who should routinely check, inspect and clean the system. There were some checks on the temperature of hot water and shower heads were cleaned regularly, but these did not meet the guidance as set out by the HSE.
We recommend the provider consults the guidance of the HSE regarding the procedures for combatting Legionnaires' disease and for protecting people from hot surfaces.

Checks were made by suitably qualified persons of equipment such as the fire safety equipment, fire alarms, electrical appliances and electrical wiring. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water. First floor windows had restrictors so people could not fall or jump out. Each person had a personal evacuation plan so staff knew how to support people to evacuate the premises in the event of an emergency. The staff were trained in fire safety and the alarms and emergency lighting were tested as required. There were contingency plans in place in the event of a fire or need to evacuate the premises.

Risks to people were assessed and monitored so people were able to stay safe whilst exercising their freedom. Care records showed risks to people were assessed with corresponding care plans to keep people safe. These included the risks of going out, crossing the road, cooking, mobility, bathing, managing finances and risks associated with eating. We noted one risk management plan needed some more detail about supporting a person with bathing, which was completed following the inspection.

Sufficient numbers of staff were provided to meet people's needs. Staffing was arranged to meet individual

people's needs. This included people being supported by staff on a one to one basis for activities such as going out. We observed there were enough staff to support people in the home and for taking people to activities in the community. Staffing consisted of at least two staff from 8am to 5.30pm plus additional staff for individual activities with people. At night time there was one staff member on a 'sleep in duty.' The manager's working hours were in addition to this.

The provider had policies and procedures for checking new staff were safe to work in care setting. This included obtaining references and a Disclosure and Barring Service (DBS) check. The DBS maintains records of those people who are considered not safe to work in a care setting. The provider informed us that the staff recruitment process incorporated the principles of treating staff fairly and equally irrespective of age, disability, gender, religion or sexual orientation.

Medicines were safely managed. Staff were trained to handle medicines and to support people to take their medicines; this included an observed assessment that staff were competent to do this. Records were maintained by staff when they supported people to take their medicines. Medicines were stored safely.

The home was found to be clean and hygienic. Staff were trained in the prevention of infection and in food hygiene. The kitchen was found to be clean and checks were made that the food was stored at the correct temperature.

Care records showed incidents were reviewed and arrangements for care updated when needed. Incident and accident forms were completed when needed and the provider had a system whereby this information was reviewed by a team at the provider's head office.

Good

Is the service effective?

Our findings

There were good links with organisations so that staff skills were updated and current guidance was followed regarding the care of people. This included links with the local authority learning disability forum and national organisations so that current guidance on learning disability conditions such as autism and Fragile X syndrome was available to staff. The provider's national team also provided updates for the staff on current guidance on the care of people. Relatives said staff were skilled in the care of people and had links with specialist organisations regarding specific conditions. Staff were supported to develop their skills and knowledge to ensure people received effective care. The provider had policies regarding the training and development of its staff. This included those areas which needed to be included in the staff induction as well as ongoing training. There was a notice board with information for staff on training courses and the provider's policy of promoting staff career development. Training records showed staff had attended courses in a range of subjects such as the Mental Capacity Act 2005 (MCA) and the Deprivation of liberty Safeguards (DoLS), child protection, moving and handling, data protection, health and advocacy, person centred care and challenging behaviour. Staff were trained in equality and diversity and had a good understanding of people's rights irrespective of their age, race or disability. Training was recorded on an IT system whereby the manager could monitor the completion of staff training.

Staff told us the training was of a good standard and that they were supported to develop their skills and knowledge. This included enrolling on the Care Certificate as part of the induction of newly appointed staff. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. The manger was qualified in the Diploma level 5 in leadership and management. Each of the care staff was qualified to level 2 or 3 in the Diploma in Health and Social Care or NVQ. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Staff said they received regular supervision and were able to discuss their training needs. Records of staff supervision were maintained.

People were able to choose meals at the weekly house meetings when menus were planned. People said they liked the food and that there was choice. Relatives also said they considered the food was of a good standard. For example, one relative said, "The food is great. It's nourishing." People's nutritional needs were assessed and specialist diets catered for where this was needed. The staff liaised with local health care services regarding dietary provision when appropriate. Food stocks included plentiful amounts of fresh produce including fresh fruit and vegetables. People were able to help themselves to drinks and snacks and also helped in some of the meal preparations. People's weight was monitored so action could be taken if people lost or gained weight.

Each person had a health care file with comprehensive details of their health needs. This included a health care passport with information about health care needs which could accompany the person should they be admitted to hospital. The health care file showed people's health care needs were thoroughly assessed and

arrangements made for people to have regular checks at the dentist, optician and GP as well as an annual health care check. The staff also referred people and liaised with more specialist health care services such as learning disability nursing services, clinical psychologist and occupational therapy services.

The premises were suited to the needs of the people. There was adequate outdoor and indoor space which people were observed using. Each bedroom was single and was decorated in colours chosen the person whose room it was. Bedrooms were personalised with people's own belongings, including their own furniture if they wished. People said they liked their rooms.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Each person at the home was subject to a DoLS. At the time of the inspection these were being updated by the local authority to reflect the change of address as each of the five people at the home had recently moved there. We observed people were consulted about daily activities and what they would like to do. Staff gave people time to make a decision which was respected by the staff member. Care records included best interests decision meetings where people were unable to give consent to treatment such as for dental care. Staff were trained in the MCA and a good understanding of the principles of the legislation.

Good

Is the service caring?

Our findings

People were treated by staff with kindness, respect and compassion. For example, a relative told us the staff had a good awareness of people's vulnerability and were very caring. This same relative commented that the staff had been effective in improving people's mood and confidence, adding, "It's wonderful. They've been absolutely fabulous." Another relative said, "The staff are very good. I could not wish for more." A person living at the home described the staff as kind and friendly.

Staff were observed to interact well with people; they knew people well and people were comfortable in their company and in talking to them. The manager and staff listened to people and spoke to people with kindness and warmth. Staff and relatives described the service as being like a family home.

Staff demonstrated to us they were committed to promoting people's rights to access services and the community. One staff member said their training and the values of the service emphasised supporting people to have a better life. The provider had a diversity and equality statement to promote a culture of equality, respect and dignity and to not tolerate any form of discrimination. We found these values were reflected in the service people received. The statement also referred to people and staff being supported to develop their full potential. A relative said staff supported people well so that they had become less afraid and more confident.

Care records were individualised to each person and showed care was person centred. The care plans reflected people's preferences and choices, such as daily routines and activities. Care plans showed emotional and behavioural needs were assessed and care plans included guidance for staff to prevent people becoming upset. Health and social care professionals said people were involved in decisions about their care which was also the view of people's relatives. People had access to advocates and befrienders where this was appropriate.

People were supported to maintain and develop their independence. This included people taking part in domestic activities in the home. People were supported to develop life skills. Each person had their own bedroom and each door had a lock so people could be secure and private. One person said they had a key to their bedroom door so they could lock it when they went out. Care records showed people were able to make a choice about the gender of staff who would provide support with personal care.

Good

Is the service responsive?

Our findings

People received personalised care which was responsive to their needs. Assessments of people's needs and care plans were comprehensive and covered physical health care needs, mental health, social care needs and personal care. The care plans were person centred with information recorded about care under headings such as, 'Good Day, Bad Day,' and, 'How I Like and Need My Support.' Details about family relationships and who is important in people's lives was recorded. The detail in the care plans regarding the management of behaviour was well recorded, showing triggers and signs that behaviour may change and the actions staff should take. A relative and a health and social care professional stated the staff at the service had helped people with their personal development and that the numbers of incidents of behaviour which challenged others had greatly reduced.

We did note some inconsistencies in the care plans for people and the manager confirmed the care plans were being reviewed and updated. These were relatively minor such as one care plan not having information to show the action staff needed to take to prompt someone with their personal care whereas for another person this was recorded well.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. Details about people's communication needs were included in the care plans. These were recorded well and gave staff detailed information about how to communicate with people. Care plans included pictorial diagrams for easier understanding by people and information was displayed in a way people could understand and use.

People were supported to attend a range of activities either in the home or in the community. We observed a staff member discussing with one person what they wanted to do for the day. The discussion showed the person was able to choose exactly what they wanted to do. We also observed people being supported by staff to attend other activities in the local area. Staffing levels were flexible so people could have the staff support they needed. A relative said the staff were good at ensuring people got out and about. One person told us they were able to choose what they did and added they attended voluntary work which they enjoyed. People were supported to attend day services, gardening schemes and activities to support them develop independent living skills. The provider arranged for people to have a holiday and one person said they enjoyed this. People were also supported to attend social events where they could meet others. The manager and staff said people were supported to have relationships and to have choice and freedom to express themselves.

Relatives said they had a good dialogue and working relationship with the staff and manager so that any concerns were quickly resolved. Weekly house meetings gave people the opportunity to raise any issues and one person said they felt able to raise any concerns with staff. There was a complaints procedure in the Statement of Purpose.

Details about arrangements regarding possible end of life care for the future were included in care plan format where this was applicable. At the time of the inspection this did not apply to any people at the home.

Good

Is the service well-led?

Our findings

At the last inspection of 31 May 2017, we found the provider had failed to notify us of incidents which the regulations required as being notified. These included concerns and incidents regarding the safety of people. We also found the provider's system of monitoring the quality and safety of the service was insufficient and had not identified where improvements needed to be made regarding incidents and accidents to people. We made a requirement notice for each of these. The provider sent us an action plan of how this was to be addressed. At this inspection there was no evidence to indicate incidents had occurred which the Care Quality Commission were not notified of. We also found at this inspection there was system for reviewing and reporting accidents and incidents to people. This included the completion of accident and incident forms which were passed to the provider's head office for review and any further action. There was a system for reviewing people's care needs which included the completion of behaviour forms and a review of care plans plus an update to reduce the likelihood of a reoccurrence. The provider also carried out regular reviews of the care and care plans for each person; this included actions for the manager and staff to develop and improve the care plan recording. We judged the requirements were now met.

At the last inspection of 31 May 2017, we found the provider's system of monitoring the quality and safety of the service was insufficient and had not identified where improvements needed to be made regarding incidents and accidents to people. We made a requirement notice for this. The provider sent us an action plan of how this was to be addressed. At this inspection we found there was system for reviewing and reporting accidents and incidents to people. This included the completion of accident and incident forms which were passed to the provider's head office for review and any further action. There was a system for reviewing people's care needs which included the completion of behaviour forms and a review of care plans plus an update to reduce the likelihood of a reoccurrence. The provider also carried out regular reviews of the care and care plans for each person; this included actions for the manager and staff to develop and improve the care plan recording. We judged this requirement was now met.

The service did not have a registered manager at the time of the inspection but there was a manager in post who had applied to the Commission for registration. The current residents and staff had moved to the home from another United Response location in June 2018. The staff said there had been a number of management changes for the current staff team but were positive that a new manager was in post. Relatives said the staff and management handled the move well and said people had settled down well after the move. People said they liked living at the 'new' home as it had more space than the previous home. The manager and staff said the move had benefitted people due to it being in a better location and having more space, which had positive results for people's mood.

Staff and people's relatives described the manager as approachable and effective. For example, one staff member said of the manager, "She is the best in terms of being supportive." A relative said of the leadership of the service, "You can raise any issues. They are tremendously approachable." A health and social care professional said the manager was very good. The service had a lead senior support worker who had responsibilities for coordinating care in the absence of the manager. Each shift had a designated staff member to lead on decision making in the absence of the management team. Staff said they felt supported

and the provider had systems for supporting staff with work or personal issues.

The staff and relatives described a culture where people received person centred care in a family type environment. For example, a relative said, "It's like a family. The staff know people very well. They are very fond of them." The provider promoted equality, diversity and human rights. The staff handbook included the provider's commitment to equality and diversity and staff were trained in this. Staff showed they were committed to ensuring people were treated fairly and had had access to community facilities and a good standard of person centred care.

People and their relatives were consulted and involved in decisions about care and the running of the home. People attended weekly house meetings and confirmed they were able to make decisions about the meal plans and other matters. Survey questionnaires were used to obtain the views of people, relatives and professionals about the service and the staff. The manager said surveys had not been issued since moving to the new home but would be implemented in the near future. The provider used a system which involved surveys in pictorial format for easier understanding by people.

A number of audits were used to check on the quality and safety of the service. These included a weekly financial check on people's finances and a weekly medicines audit. A comprehensive audit was carried out every three months by the provider's area manager; this covered health and safety, staff supervision, medicines and people's care plans. A health and social care professional said the service was well managed but commented there had been a lapse regarding the monitoring of one person's entitlement to benefits. The manager acknowledged this and said action was taken to ensure this was acted on and that each person's finances were checked.

The provider worked with key organisations to ensure people's needs were reviewed and that people received access to health care services.